"Dead to the world, but alive unto God": Bodily corruption, visual culture and social perceptions of leprosy in Medieval Europe

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Introduction

Few diseases have evoked such a social response throughout history as that of leprosy. Leprosy, due to the social stigma and extreme clinical manifestations associated with the disease, has been the focus of intense research among biomedical and behavioural scientists attempting to understand fluctuations in the diseases occurrence (Roberts and Manchester 2010; Waldron 2009). Despite a greater understanding of the epidemiology of the disease in the modern day, the prevalence of leprosy and its associated social stigma remains a major issue in developing countries (Suzuki et al. 2013: 121). The current prevalence of the disease across the world has allowed archaeologists and anthropologists to understand its complex social dimensions from an ethnographic perspective. Leprosy was widespread in medieval Europe (Manchester and Roberts 1989: 269), but whilst the prevalence of the disease never reached that of the plague, it was met with a social response that was disproportionate to its risk to public health.

Recent research has advocated a multifaceted approach to the study of leprosy in medieval Europe that jointly considers social, cultural, economic and iconographic evidence (Brenner 2010). This article explores how social perceptions of leprosy in medieval Europe were reinforced through contemporary visual culture. Traditionally leprosy is discussed in relation to iconographic sources that directly depicted the disease, without reference to broader artistic themes or cultural movements. Contemporary with the prevalence of leprosy in medi-

eval Europe was an artistic movement that saw a preoccupation with skeletal and cadaveric imagery, related to wider fears of bodily corruption, death and remembering one's own mortality (Binski 1996). Expressed through three key themes, the *Danse Macabre, Three Living and the Three Dead* and Cadaver tombs, or *Transi,* artistic devices such as repetition and mirroring were used to challenge the strict and rigid structure of medieval society. These themes were reflective of medieval attitudes towards death, dying and the body, which centred on fears of bodily corruption and body-soul dialogues (Harris and Robb 2013), mirroring the negative perceptions of leprosy. Through consideration of ethnographic and bio-cultural archaeological evidence, this paper argues that negative social perceptions of leprosy in medieval Europe were reflective, and influenced by, wider social constructs that were uniquely expressed in contemporary visual culture. In doing so, this paper advocates a multidisciplinary bio-cultural approach to the study of health and disease in archaeological populations.

Leprosy: Epidemiological and clinical background

Leprosy, or 'Hansen's Disease', is a chronic infectious disease caused by *Mycobacterium Leprae* which attacks the skin, mucous membranes and peripheral nerves, resulting in destructive skeletal manifestations (Martin 2010: 414). Leprosy occurs in a variety of forms, causing diverse responses depending on an individual's immunity, with lepromatous leprosy being the most severe and tuberculoid leprosy being the least (Roberts and Manchester 2010: 195). Although leprosy largely affects humans, the disease is zoonotic, having been noted to occur in Armadillos (Lumpk et al. 1983) and several primate species (Hubbard et al. 1991). Despite being one of the most widely studied communicable diseases, the exact mode of transmission of leprosy is unknown due to the difficulties of studying the disease *in vitro,* although droplet inhalation (Manchester and Roberts 1989: 265) or close repeated contact with infected skin (Job et al. 2008) are widely considered as primary causes of transmission. A distinctive trait of leprosy is the diseases long and varied incubation period, lasting up to 6 years in humans (Aufderheide and Rodriguez-Martin 1998: 147), although incubation periods of up to 30 years have been observed in wild chimpanzees (Suzuki et al. 2011).

The current geographic distribution of leprosy is largely correlated with socio-economic circumstances in developing countries, with India (127,326 new cases), Brazil (26,395 new cases) and Indonesia (17,202 new cases) considered

the most at risk in 2015 (WHO, 2015). Whilst these figures represent a significant decline from prevalence rates in 2004, resulting from multiple drug treatment (MDT) programmes, social stigma attached to leprosy in these countries is harder to eradicate, even after recovery (Roberts and Manchester 2010: 194).

The clinical symptoms of leprosy can be extreme, with both dermatological and neurological responses that result in severe deformities and disabilities. Leprosy is generally characterized by multiple skin lesions and nodules, damage to the nervous system, thickening of the brow ridge, a collapsed nasal area, the loss of the anterior dentition and the resorption of the limb extremities (Aufderheide and Rodreguez-Martin 1998: 150–153; Ortner 2003: 263–271; Suzuki et al. 2012: 123-127; Waldron 2009: 97–101). Bone resorption associated with leprosy is the direct result of nerve damage and circulatory obstruction, causing progressive sensory and motor loss, which can then give way to ulceration and secondary infection of the overlying dermal and muscular tissues (Aufderheide and Rodreguez-Martin 1998: 150; Roberts and Manchester 2010: 196). In the cranial skeleton, rhinomaxillary syndrome is the combination of several destructive proliferative lesions, which include loss of the anterior nasal spine, endonasal inflammation and recession of the alveolar process, resulting in the loss of the anterior dentition (Anderson and Manchester 1992; Aufderheide and Rodreguez-Martin 1998: 150–151; fig. 1).

In the post-cranial skeleton, the bones of the hands and feet are most commonly affected. The highly vascular bone of the epiphyses results in bilateral diaphyseal remodelling, resorption of the distal phalanges and pitting on the tarsals and metatarsals of the feet and the carpals and metacarpals of the hands (Ortner 2003: 267–268). The clinical manifestations of leprosy greatly contribute to the social component of the disease, whilst also contributing to the socio-economic and psychological challenges of the disease experience.

Leprosy in the archaeological record

The rise of leprosy is documented through skeletal, documentary and material evidence. Manchester and Roberts (1989: 226) highlighted the traditional view that leprosy originated in Asia, citing Indian and Chinese medical texts dated to the late second half of the first millennium BC as offering dependable descriptions of advanced leprosy. Hulse (1972) suggested Egyptian texts, dated

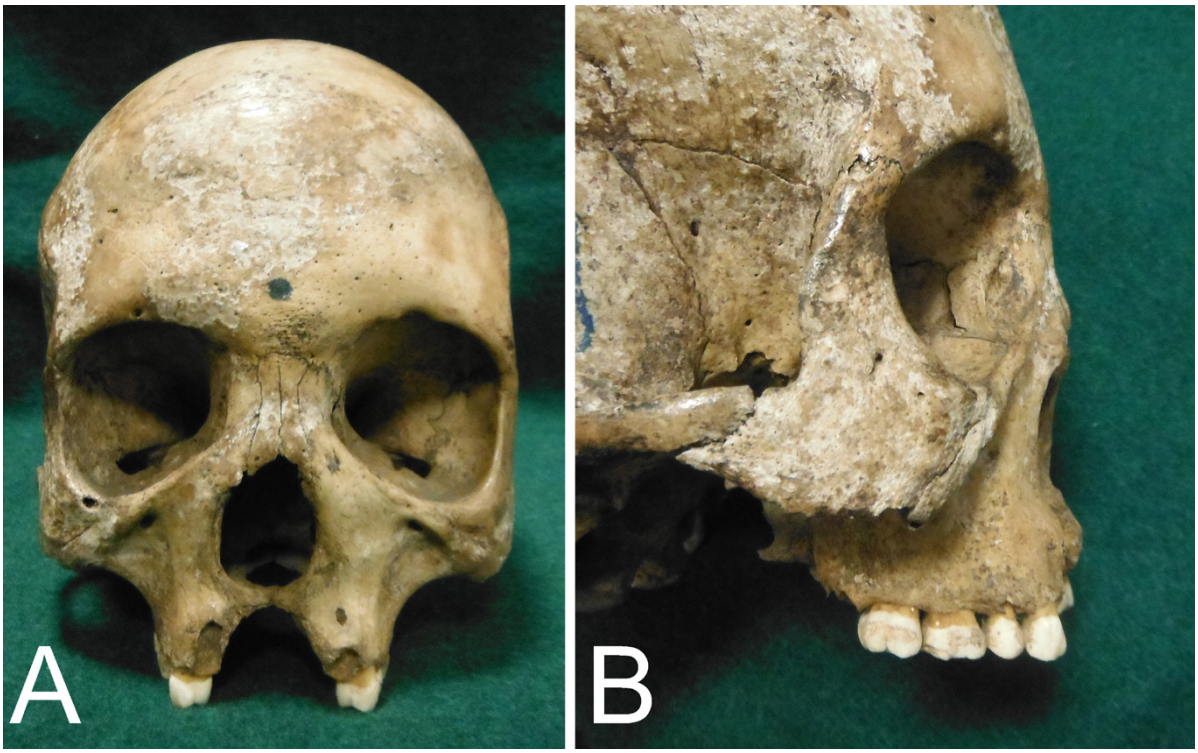

Fig 1. Cranial lesions associated with leprosy, including resorption of the alveolar region (A) and anterior nasal spine (B) resulting in antemortem tooth loss. (Photographs by Eóin W. Parkinson, with the permission of Emma Devereaux, Duckworth Laboratory, University of Cambridge).

to 1550 BC, allude to leprosy and references to leprosy are widely associated with the book of Levitucus from the Old Testament, 1500-1400 BC (Kaplan 1993). Whilst the occurrence of Biblical leprosy has since been the subject of debate, it being generally accepted that Biblical leprosy likely described a variety of dermatological conditions (Kaplan 1993; Macarthur 1953: 8), these references represent some of the earliest expressions of the stigma attached to leprosy, which would later become the agent behind the negative perceptions of the disease in medieval Europe. Biblical infallibility in medieval Europe produced an atmosphere of fear and hate towards individuals suffering from leprosy, which was reflective of the influence of the Church over medieval society. The inextricable link between the Church and medieval society ultimately obscured the boundaries between the medical and theological definitions of leprosy.

Robbins et al. (2009) demonstrated that lepromatous leprosy was present in India as early as 2000 BC, pushing the date back for the earliest occurrence of the disease. Analysis of a middle aged male individual at Balathal, India, exhibiting osteological lesions comparable to rhinomaxillary syndrome supports

the textual evidence for an eastern origin for the pathogen. Possible skeletal lesions associated with leprosy observed in four individuals at Dakhleh Oasis, Egypt, dating to the second century BC (Dzierzykray-Rogalski 1980), suggest that leprosy may have least spread east to west during the second and first millenniums BC. Manchester and Roberts (1989: 266) suggested that the apparent segregation of these individuals within the necropolis was similar to the treatment of leprosy sufferers in medieval Europe, suggesting that in its earliest occurrences the disease resulted in differential treatment of individuals.

The westward spread of leprosy was further confirmed by molecular analysis of European and Middle Eastern strains of the disease (Schuenemann et al. 2013). It is traditionally considered that that leprosy was brought westward by the armies of Alexander the Great on return from their Indian Campaign (356-323 BC) (Roberts and Manchester 2010: 201), however, Mark (2002) argued that the westward spread of leprosy was related to seafarers involved in the Indo-Egyptian slave trade routes. Although, the discovery of a possible leprous individual in Bologna, Italy, from the fourth to third century BC has shed doubt on the Alexandrian theory (Mariotti et al. 2005).

Osteological evidence for the occurrence of leprosy is infrequent for the duration of the first millennium AD (Belcastro et al. 2005; Blondiaux et al. 2016; Reader 1974). Evidence for late Romano-British leprosy at Poundbury presents the earliest known case of the disease in northern Europe in the fifth century AD, with the frequency of leprosy remaining relatively low from the fifth to tenth centuries AD (Blondiaux et al. 2016; Manchester 1981), however, in the middle and later medieval period leprosy made a significant increase. Where the osteological evidence for leprosy is limited, as in Ireland (Buckley 2008; Murphy and Manchester 1998), consideration towards associated material culture and visual sources demonstrates an increase in the diseases prevalence. Buckley (2008) considered the use of places names in supporting the occurrence of leprosy in Ireland, for example Leopardstown (*Baile na Lobhar*), Dublin, translating to "town of the Lepers". Furthermore, the presence of "leper squints" in churches, which offered those with leprosy and other excluded individuals access to church services without direct contact with the public, provides useful evidence for leprosy where osteological evidence is otherwise not available. Leprosy is also directly illustrated in artistic sources, with individuals usually being depicted displaying non-specific skin ulcers (Murphy and

Manchester 1998), although examples of sculpture exhibiting the clinical manifestations of leprosy in greater detail do exist (Manchester and Knüsel 1994).

Within Britain, the rise of leprosy may have been the result of increased urbanization and population density in the eleventh century AD following the Norman Conquests (Brown 1985: 86), or population movements associated with trade, military or religious action. The sharp rise in the establishment of leprosaria from the eleventh to thirteenth centuries AD within Britain is demonstrative of the rise in leprosy (Manchester 1984), whilst on continental Europe, there were an estimated 19,000 so called "leper-houses" during the thirteenth century AD (Zimmerman 2008: 561). In light of this rapid increase, it is perhaps comprehensible how leprosy triggered an extreme social response which resulted in such in negative treatment and segregation, all of which stemming from the ecclesiastical doctrine of the time.

From the fourteenth century AD onwards there was an observable decline in leprosy, although recent research by Blondiaux et al. (2016) has suggested a later seventeenth century date for the diseases decline. This decline is seen through the decreased frequency of skeletal, documentary and material culture evidence for the disease. The sharp reduction in the number of leprosaria founded during the fourteenth to sixteenth centuries has also been used to interpret the decline of leprosy (Manchester and Roberts 1989), although these conclusions were based on figures related to the foundations of new leprosaria, and therefore do not represent the total number of functioning leper hospitals. The decline of leprosy in medieval Europe has been traditionally attributed to secondary effects associated with the rise in tuberculosis during the Late Medieval and Post-Medieval periods (Lietman et al. 1997) or the fluctuating population in the medieval period resulting from the Black Death and subsequent plague outbreaks (Gottfried 1983: 14; Richards 2013: 161).

Tuberculosis is a chronic infectious respiratory disease caused by *Mycobacterium Tuberculosis* that can result in severe skeletal manifestations. Sharing the same genus as leprosy (Ortner 2003: 229–260), the two diseases are related in both a biological and social context. Manchester (1984) recognized the biological relationship between leprosy and tuberculosis, suggesting that a tuberculosis infection created immunity from the leprosy bacillus, causing cross-immunity on a population wide scale and the eventual decline of leprosy, although the

cross-immunity hypothesis has since been challenged (Hershkovitz et al. 2008; Lietman et al. 1997; Schuenemann et al. 2013; Segerstorm and Miller 2004).

Visual culture and bodily corruption

The extreme clinical symptoms of leprosy, which in medieval Europe were considered the external manifestation of internal sin (Zimmerman 2008: 581), left affected individuals susceptible to a level of segregation and social exclusion that was disproportionate to the risk to public health. The fear of leprosy ran in parallel to a macabre artistic movement that saw an obsession with death and remembering one's own mortality (Binski 1996; Huizinga 1924). The concept of *memento mori,* meaning "remember your mortality", had its origins in Classical (Lucie-Smith 2013: 7; West 1995) and Early Medieval literary and artistic traditions across Europe (Oosterwijk, 2009), which endured and proliferated through to the mid-seventeenth century AD (Harris et al. 2013; Hunter 2000; McCormack 2007; Parkinson 2013). Whilst earlier incarnations of *memento mori* were primarily optimistic nature, by the medieval period the concept of *memento mori* developed a bleaker tone (Spinrad 1987: 2). During the medieval period, *memento mori* themes were principally expressed through three key forms—the *Danse Macabre, Three Living and the Three Dead* and Cadaver tombs (Binski 1996)—which presented death as the great leveller. The use of artistic devices, such as mirroring and repetition, were utilized to directly compare the living and the dead, prompting the viewer to contemplate and self examine. In medieval Europe, individuals with leprosy personified the conflict between life and death—emblematic of the social atmosphere of the time (Brenner 2010), they embodied the very essence of contemporary public and funerary iconography.

The earliest of the three key themes is the legend of *Three Living and the Three Dead*. With origins in Early Medieval French poems and English literature centred on the decomposing body (Oosterwijk 2004: 62), the legend tells the tale of three noblemen, typically featured in fine garments, who encounter three deceased individuals, depicted as decomposing corpses and sometimes wearing similar clothing to their living counterparts. The subsequent dialogue sees the dead individuals tell the living "What you are now, so once were we, what we are, so you shall be" (Daniell 1997: 69), urging the living to change their ways. The use of *doppelgängers* and repetition within the *Three Living and the Three Dead* can be considered as

Fig. 2. The Scientist and the Bourgeois tableau from the Dance of Death featured in le cimetière des Innocents, Paris (By Guyout Merchant 1486). Figure reproduced with the permission of Patrick Pollefeys (www.lamortdanslart.com).

representing the personification of death, but more likely as the mirroring of three living individuals with three corrupted dead counterparts (Binski 1996: 138).

The second key aspect of the macabre is the Dance of Death, or *Danse Macabre*, which developed in Franco-German literary and dramatic traditions (Daniell 1997). The *Danse Macabre* gained considerable popularity during the Middle-Late Medieval period, playing a vital role in the wider preoccupation with the macabre artistic themes. Depictions of the Dance of Death were located in prominent public places and featured a series of tableaus where skeletons, personifying death, visited people of various social standings (Daniell 1997: 69). The skeletons guided the viewer through a jaunty dance with apparent vivacity and aggression, whilst the living subjects appeared stiff and reluctant (fig. 2). The Dance of Death was often associated with sinful themes of a sexual or mocking nature that had also developed in wider European art up to the fifteenth century AD (Ariés 1972: 58; Binski 1996: 155). Whilst the format of the Dance of Death varied considerably geographically and chronologically

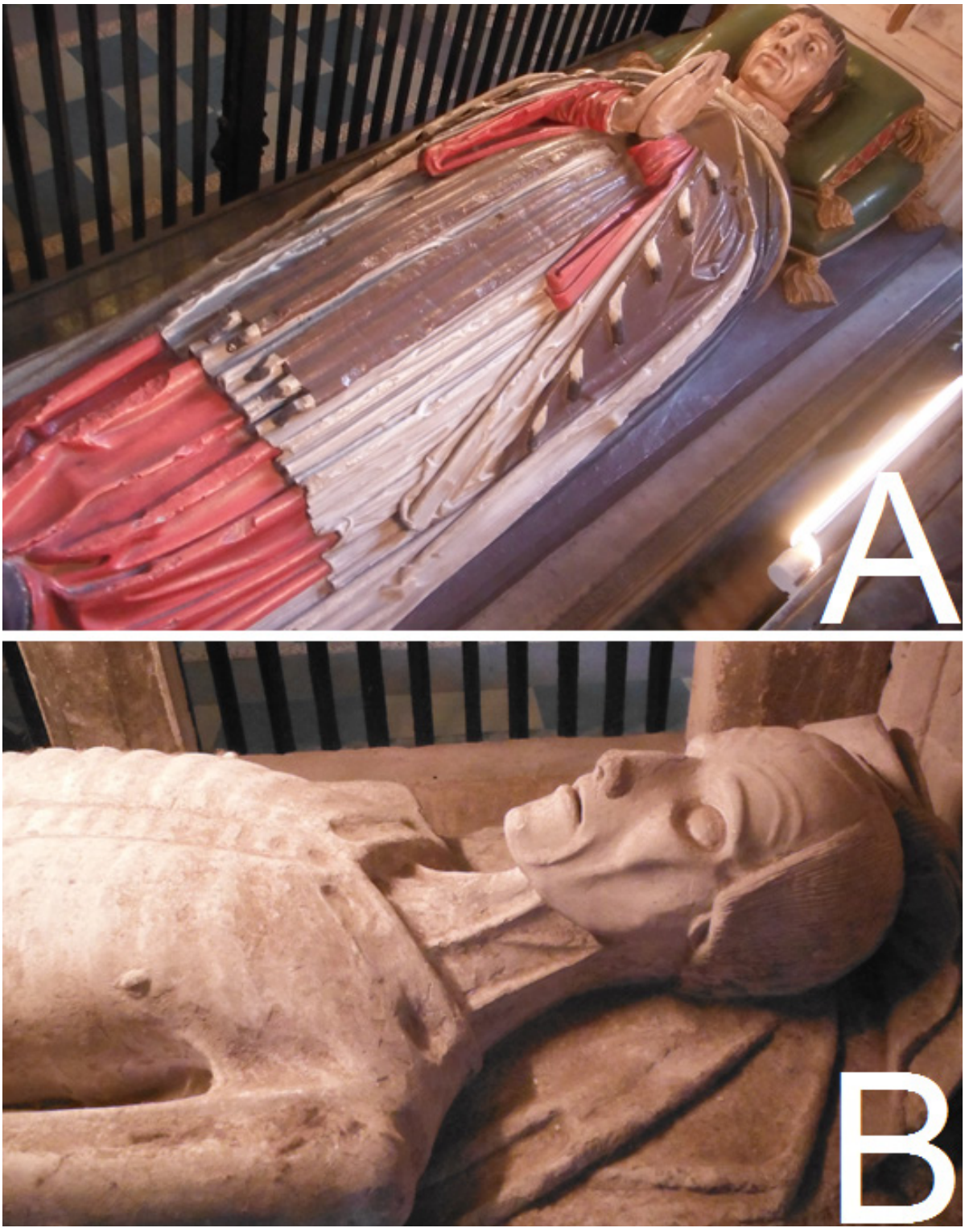

Fig. 3. Cadaver tomb of Hugh Ashton, St. John's College, Cambridge (c. 1522). A) Depiction of Ashton in as in life, B) Depiction of Ashton as naked, emaciated and decomposing corpse. Photographs by Eóin Parkinson with the permission of Tom Kirk, St. John's College Chapel.

(Oosterwijk 2008), the message remained the same. The overriding message was again *memento mori*, but the significance of the Dance of Death is in how it acted as a social critique, enforcing the egalitarianism of death and irrelevance of social standing (Huizinga 1924: 141)—although the notion that the Dance of Death was a social critique has been fiercely challenged, with suggestions that public representations of the Dance of Death acted as a form of wider public chastisement (Mackenbach 1995; Mackenbach and Drier 2012).

The third and final key theme of the medieval *memento mori* tradition was the Cadaver tomb, or *Transi*. Cadaver tombs created a clear connection between the physical states of life and death, using highly realistic and graphic sculpture to play on medieval fears of bodily corruption (Ariés 1972: 42; Platt 1996: 158). In this particular funerary memorial form, the deceased was depicted atop a funeral bier in their finery, which was then paralleled below with a representation of an exposed decomposing corpse (fig. 3). As Figure 3 shows, Cadaver tombs were the most condensed and visually striking of the three themes, accurately illustrating the contrast between the pure living body and the corrupted flesh of the deceased, following the departure of the soul (Harris and Robb 2013). Although Cadaver tombs represent a later incarnation of *memento mori* imagery, developing in the early fifteenth century AD (Oosterwijk 2005: 40) and following the early stages in the decline of leprosy (Manchester 1984), these memorials nonetheless provide an example of the proliferation of macabre themes in medieval visual culture and exemplify the broader cultural, religious and iconographic context of the medieval period (Cohen 1973: 4).

Discussion

Individuals affected by leprosy in medieval Europe represented a state between life and death, embodying sentiments expressed in contemporary visual culture. Medieval funerary art was inextricably bound in fears surrounding bodily corruption, which itself was a major aspect of medieval Church's doctrine (Ariés 1972: 41–44). Whilst the medieval understanding of the body was extremely complex and varied, the Christian Church defined it as a corruptible collective of mortal flesh, in direct opposition to the incorruptible soul—the medieval body thus became a "theological battleground" (Harris and Robb 2013) where body-soul dialogues created channels between sin and the decaying body (Osmund 1974: 364). As the medieval belief system saw the living body as incorruptible, it was only

after the soul left the body could flesh become corrupted (Harris and Robb 2013). The clinical manifestations of leprosy, which paralleled the process of decomposition in the medieval imagination, thus developed a particular significance.

The obliterative lesions of leprosy were considered external manifestation of internal sin and the souls corruption (Zimmerman 2008: 561). This concept was most clearly demonstrated by the apparent incorruptibility of saint's bodies (Cruz 1997). With the body remaining at the centre of religious imagery and allegorical devices throughout the medieval period (Binski 1996: 123; Matthew, 26:26, New King James Bible), individuals with leprosy became agents of these religious and societal fears of bodily corruption. These attitudes were largely based on biblical references to *Zara'at*, a skin ailment which was later attached to leprosy and associated with divine punishment, sexual promiscuity and moral corruption. This connection between sin and leprosy justified the exclusions of individuals with leprosy under the teachings of the Church (Zimmerman 2008: 561), which largely dictated all aspects medieval society.

In this social context, the pronounced clinical manifestations of leprosy led it to acquire a reputation as the "living death" in the medieval imagination, an idea clearly influenced by the rhetoric of the bible which deemed those with leprosy as the "first born of Death" (Job 18:13, New King James Bible; Murphy and Manchester 1998). This sentiment was further echoed in the segregation rite for individuals suffering from leprosy in medieval Europe, which consisted of a graveside ceremony that symbolically resembled a funeral and undertaken by a Priest who recited a list of prohibitions before pronouncing the individual dead to the world (Murphy and Manchester 1998). These segregation rites laid the framework for the social exclusion of affected individuals, which while imposed by society, was to be self-regulated. In an ethnographic study of individuals with leprosy in Hawaii, Amundson (2010) demonstrated that negative perceptions of leprosy are more so focused around western perceptions of bodily difference, rather than public health concerns related to the infectious nature of the disease. Although it is erroneous to draw direct parallels between modern and archaeological lived experiences, it is likely that social perceptions of leprosy in medieval Europe were heavily influenced by contemporary concepts of bodily difference, which were very much apparent in funerary art.

Individuals with leprosy where considered ecclesiastically dead, as well as dead to society through banishment. Deviating from the life cycle, they were considered to have reached a state of purgatory between life and death, and therefore personified contemporary medieval religious and societal beliefs on the soul's corruption. In the same way that the *Danse Macabre*, Cadaver tombs and the legend of the *Three Living and the Three Dead* challenged the stability and regularity of society by mirroring life and death, those suffering from leprosy in medieval Europe equally represented the conflict between life and death, capturing the zeitgeist of medieval Europe and its concerns over bodily corruption, paradoxically becoming an "alien yet intimate stranger" (Zimmerman 2008: 578).

Despite the decline in leprosy, the impact of the Black Death in triggering greater concerns surrounding sanitation and infection in medieval society would have created an even more hostile social environment for individuals suffering form leprosy, which cannot be fully discussed here. The influence of the Black Death on medieval funerary art has been widely discussed and contested (Binski 1996; Gottfried 1983; McCormick 1983: 267). Whilst it is evident that macabre themes in medieval funerary and public iconography pre-date the Black Death, it is clear that *memento mori* art had departed from the levity recognized in pre-plague examples (Oosterwijk 2009). Ultimately discussions relating to wider debates of society in medieval Europe are needed to fully understand the social perceptions of the disease.

Brenner (2010) suggested the stigma attached to leprosy in medieval Europe must be viewed as being incredibly varied and nuanced, dependent on a myriad of social and individualized personal factors. It is clear that there was interplay between wider negative social perceptions of leprosy in medieval Europe and contemporary visual culture; therefore, living in this cultural atmosphere would have greatly impacted on the lived experience of the disease. Whilst exploring disease experiences in archaeological contexts is problematic, ethnographic accounts of leprosy can lend useful insights into intangible aspects of the lived experience of those affected by the disease in medieval Europe. Barrett's (2005) study of leprosy in India draws several clear parallels with medieval Europe, where affected individuals, and those associated with them, face social exclusion and severe economic losses. Barrett's (2005: 221–222) work has shown that the socio-economic effects of the disease often lead to individuals begging, concealment through clothing and exclusion from group ceremonial activities,

echoing the treatment of individuals suffering from leprosy in medieval Europe. These processes have been shown to extend to relatives and those who financially support leprous individuals (Amundson 2010). Even a consideration towards the practical aspects of leprosy, namely the loss of limb extremities or motor function resulting from nerve damage associated with the disease, can render affected individuals physically impaired, which in traditional societies has been demonstrated to have a considerable impact on the economic circumstances of an individual or their wider family (Kress and Herridge 2012).

The stigma attached to leprosy has been shown to be complicated and varied, dependent on the cultural, social and economic status of an afflicted individual (Staples 2011). Staples' (2011) research compliments broader theoretical approaches to the archaeology of disease and caregiving which address the problem of intangible personal factors, such as the socio-economic status or personality of an individual, which would have influenced care provisions and disease lived experiences in archaeological contexts (Brenner 2010; Tilley and Oxenham 2011). Brenner (2010) highlighted recent arguments that counter the predominant view that medieval perceptions of leprosy were largely negative, suggesting that affected individuals represented sympathy and compassion in medieval society. In particular, Brenner (2010) cites the endowment of leprosaria and notable examples of high status individuals who suffered from leprosy, such as King Baldwin IV of Jerusalem (Mitchell 2000), as examples of compassionate or differential treatment related to the disease in medieval Europe. Whilst it is evident that aspects of care and compassion were afforded to individuals with leprosy, the case of King Baldwin IV cannot be considered as typical given his social status.

The psychological impact of a disease is also a significant component of the lived experience of leprosy (Tilley and Oxenham 2011), which is otherwise not evident in the archaeological record. In a study investigating mental health in leprosy suffers in modern India, Tsutsumo et al. (2003) noted higher than average incidences of depression in individuals affected by leprosy, citing physical attacks and processes of 'othering' as the main determinants. These processes of societal isolation have also been widely demonstrated to result in self-neglect and self-harm (Barrett 2005; Pearson 2014). Whilst it is impossible and improper to draw direct comparisons between modern and medieval lived experiences, it is likely that those with leprosy in medieval Europe suffered similar psychological health issues. In the social and iconographic context of medieval

Europe, where bodily corruption was central to the teachings of the Church, alongside strict social constructs of bodily norms, affected individuals would have been victim to processes of 'othering' arising from a combination of economic and cultural factors, resulting in physical and psychological health issues.

Conclusion

Brenner's (2010) call to employ a multidisciplinary approach to the study of leprosy that involves social, political, cultural and iconographic evidence has laid a framework for future research directions. Whilst leprosy is often considered as a "social disease" (Manchester and Roberts 2010), wherein abundant multidisciplinary research has sought to contextualize the pathogen, previous research has largely focused on direct evidence of leprosy, rather than broader social contexts. In contrast, this paper has explored leprosy in its social and iconographic contexts related to wider fears of bodily corruption in an attempt to understand the lived experience of the disease in medieval Europe.

The emphasis on visual culture with macabre themes of bodily corruption in this paper is not intended to provide a simple answer to the factors that drove negative social perceptions of leprosy in medieval Europe. Although social perceptions of leprosy were multifaceted, *memento mori* iconography does indicate the presence of strict social constructs that dictated concepts of bodily difference in medieval Europe—strict constructs that individuals affected by leprosy in medieval Europe would have been subjected to. Therefore, it is highly likely that social perceptions of leprosy in medieval Europe were reinforced through the proliferation of such visual culture.

Aside from bringing leprosy into its broader social context, this paper also considered theoretical frameworks associated with compassion and caregiving. Often studies related to caregiving in archaeological contexts are focused on evidence of such behaviour, rather than cases that demonstrate a lack thereof. Whilst the visual component of leprosy is a factor in social exclusion, the debilitating and disabling effect of the disease means that individuals with leprosy are often physically impaired. As such, studies of leprosy should be drawn into wider discussions related to disability (Tilley and Oxenham 2011).

By drawing on medieval funerary iconography and ethnography, this paper advocates a multidisciplinary bio-cultural approach to the study of disease in

past societies. This paper also brings leprosy, and its debilitating symptoms, into the broader theoretical framework of the archaeology of care (Tilley and Oxenham 2011). Whilst this paper focuses solely on the cultural and iconographic context of leprosy, future work directed towards understanding cross-regional variation in the treatment of leprosy should be undertaken. Furthermore, whilst the effect of the Black Death has been widely considered in the demise of leprosy, possible effects of the heightened awareness in public health and sanitation following plague outbreaks, and whether these resulted in negative or constructive perceptions towards leprosy should also be further explored.

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